Washington State Department of Social & Health Services

AGING AND DISABILITY SERVICES ADMINISTRATION
ADSA NURSE DELEGATION
(See detailed fingerprint card instructions)
BACKGROUND AUTHORIZATION

Instructions for completing this form on reverse side.
Please print clearly and use BLACK INK.

DSHS Background
Check Central Unit
PO Box 45025
Olympia, WA 98504-5025
(360) 902-0299
FAX (360) 902-0292

SECTION 1. AGENCY INFORMATION (COMPLETED BY AGENCY STAFF AND CONTRACTING AGENCY OR INDIVIDUAL)

1. NAME OF DSHS OFFICE TO WHICH THIS FORM SHOULD BE RETURNED

ADSA NURSE DELEGATION
PO BOX 45600
OLYMPIA WA 98504-5600

2. A. NAME AND ADDRESS OF CONTRACTING AGENCY

2. B. IF NOT A CONTRACTING AGENCY, NAME AND ADDRESS OF INDIVIDUAL NURSE

3. TELEPHONE NUMBER FOR BOX 1 (INCLUDE AREA CODE)
(360) 725-2552

4. FAX NUMBER FOR BOX 1 (INCLUDE AREA CODE)
(360) 407-0207

SECTION 2. ALL QUESTIONS IN THIS SECTION MUST BE COMPLETED BY THE APPLICANT (PERSON TO BE CHECKED)

5. SOCIAL SECURITY NUMBER (OPTIONAL)

6. DATE OF BIRTH (MM/DD/YYYY)

7. GENDER ☐ Male ☐ Female

8. ETHNICITY (OPTIONAL)

CURRENT NAME

9. LAST NAME

10. FIRST NAME

11. MIDDLE NAME **(WRITE NONE IF NONE)**

OTHER NAMES YOU HAVE BEEN KNOWN BY

12. BIRTH NAME LAST FIRST MIDDLE

13. OTHER MARRIED NAME (S) **(WRITE NONE IF NONE)**

14. NICKNAME (S)/OTHER NAME (S) **(WRITE NONE IF NONE)**

	YES	NO
15. Have you been convicted of, or do you have charges pending for any crime?..... If yes, give the crime, the conviction date or charge status and the state where it occurred.	☐	☐
16. Have you ever been found to have sexually abused, physically abused, neglected, abandoned or exploited a child or adult? ..... If yes, give name of court, state licensing board, disciplinary board, or dependency action, details of the finding, and the state where it occurred.	☐	☐
17. Have you ever had a contract and/or license to care for children or adults denied, terminated, revoked, or suspended? ..... If yes, give date, contract and/or license type, name of contracting and/or licensing agency, and the state where it occurred.	☐	☐
18. Has a court ever issued an order of protection against you for abuse, neglect, financial exploitation, domestic violence, or abandonment? If yes, give date, court, and the state where it occurred.....	☐	☐

19. DRIVER'S LICENSE OR STATE IDENTIFICATION NUMBER **(WRITE NONE IF NONE)**

20. PRESENT NUMBER OF CONSECUTIVE YEARS LIVED IN WASHINGTON STATE
YEARS: MONTHS:

☐ CHECK IF DSHS FINGERPRINT CHECK COMPLETED WITHIN LAST THREE YEARS

21. I understand that I am signing this statement under penalty of perjury. The above statements are true and complete to the best of my knowledge. I understand that any untruthful or purposefully misleading answer or any deliberate omission may result in my immediate disqualification as a provider, caretaker, licensee, contractor, and/or as an individual authorized to care for vulnerable adults or children. I hereby authorize DSHS to obtain background information including but not limited to, convictions, licensing, child and adult protective services, and professional licensing records, from any law enforcement, any state and federal agency including other states and the FBI. DSHS is hereby authorized to release the result of this and any DSHS prior background check information to the agency, facility, entity, or individual named above.

22. SIGNATURE OF PERSON TO HAVE BACKGROUND CHECK OR PARENT/GUARDIAN

23. DATE (DATE SIGNED MUST BE WITHIN THE LAST THREE MONTHS)

INSTRUCTIONS FOR COMPLETING THE AUTHORIZATION FORM

This form will be returned if any portion of the required information necessary to conduct a background check is not entered or is not legible.

A fingerprint card is required for those applicants who have not lived in Washington State for the past three (3) consecutive years. Contact DSHS office identified in Section 1, Number 1 for instructions on how to obtain a fingerprint card.

A fingerprint card is not required if the applicant has completed a DSHS fingerprint-based check within the past three (3 years) and has not lived outside the state since the last fingerprint check. Please indicate that in Section 2, Number 20. DSHS will use the previous result when completing this background check.

SECTION 1:

1. Completed as per ADSA program manager.
2. A. To be completed by contracting agency. Required
2. B. If not a contracting agency, to be completed by individual nurse. Required
3. Completed as per ADSA program manager.
4. Completed as per ADSA program manager.

SECTION 2: To be completed by the applicant (person to be checked).

5. Optional.
6. Required.
7. Required.
8. Optional.
9. Required. Must write NONE if none.
10. Required. Must write NONE if none.
11. Required. Must write NONE if none.
12. Required. Must include complete name at birth. If same as #9 through #11, must write SAME.
13. Required. Must list all married names used (male or female); must write NONE if none.
14. Required. Must list all nicknames used (male or female); must write NONE if none.
15. Required.
16. Required.
17. Required.
18. Required.
19. Required. Must list drivers license number or state identification number; must write NONE if none.
20. Required. Indicate number of consecutive years and/or months lived in Washington State. Check the box provided if a DSHS fingerprint check was completed within the last three years.
21. Read prior to moving to block 22.
22. Required signature of applicant or parent/guardian if applicant is under 18.
23. Required. The Background Check Central Unit must receive the background authorization form within three (3) months from the date of the signature.

For complete information on DSHS Background Check Policy, please see Title 388 at:
http://slc.leg.wa.gov/wacbytitle.htm

Upon completion, submit form and fingerprint card if applicable to:

ADSA NURSE DELEGATION
PO BOX 45600
OLYMPIA WA 98504-5600